SELF-CERTIFICATION RETURNS
Organisation Name:
Portsmouth Hospitals NHS Trust
Monitoring Period:
September 12
NHS Trust Over-sight self certification template

Returns to South Central SHA by the last working day of each month

TFA Progress

Oct-12

<INSERT TRUST NAME HERE>

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1	Ensure delivery of CIPs and financial plan	Mar-12	Fully achieved in time	
2	Q1 Performance and Financial Review: 2011/12 Financial Plan on Track, Cost Improvement Plan trajectory delivered, and service performance all on track	Jul-11	Fully achieved in time	
3	Q2 Performance and Financial Review: 2011/12 Financial Plan on Track, Cost Improvement Plan trajectory delivered, and service performance on track	Oct-11	Fully achieved in time	
4	Portsmouth and South East Hampshire Estates Plan agreed and implementation underway	Oct-11	Fully achieved in time	
5	2011/12 Financial Plan on Track, Cost Improvement Plan trajectory delivered, and service performance on track	Jan-11	Fully achieved in time	
6	First formal submission to include: high level strategy and Long Term Financial Model	Feb-12	Fully achieved in time	
7	Submission of enabling strategies for Strategic Health Authority review, to include, for example, estates, Information Technology, workforce and risk.	Mar-12	Fully achieved in time	
8	Board Observation	Mar-12	Fully achieved in time	
9	Strategic Health Authority Medical / Nurse Director Visit and Quality Governance sign off	Mar-12	Fully achieved in time	
10	Executive to Executive meeting	Apr-12	Fully achieved in time	
11	Strategic Health Authority Feedback to Trust within 10 days	Apr-12	Fully achieved in time	
12	Confirm delivery of 2011/12 financial plan, Cost Improvement Plan delivery, performance against national targets	May-12	Fully achieved in time	
13	Strategic Health Authority Shadow Historical Due Diligence commences	Jun-12	Fully achieved in time	
14	First formal submission to include complete draft of Integrated Business Plan, Long Term Financial Model, consultation/engagement documents and an update on Board development and quality action plan.	Jun-12	Fully achieved in time	
15	Q1 Performance and Financial Review: 2012/13 Financial Plan on Track, Cost Improvement Plan trajectory delivered, and service performance on track	Jul-12	Not fully achieved	
16	Strategic Health Authority meeting with commissioners to discuss alignment	Jul-12	Fully achieved in time	
17	Consistently green for governance against Monitor compliance framework.	Sep-12	Not fully achieved	
18	Department of Health confirm to Department of Health Trust ready for Historical Due Diligence	Sep-12	On track to deliver	
19	Second formal submission to include complete draft of Integrated Business Plan, Long Term Financial Model, consultation/engagement documents=	Sep-12	On track to deliver	Submitted July, next iteration due 21 September 2012
20	Board to Board to approve consultation/engagement refresh	Oct-12	Fully achieved in time	Readiness Meeting held, communication and engagement strategy to be approved by Trust Board
21	Q2 Performance and Financial Review: 2012/13 Financial Plan on Track, Cost Improvement Plan trajectory delivered, service performance on track	Oct-12	Not fully achieved	
22	Consultation/Engagement	Dec-12	On track to deliver	
23	Third formal submission to include draft of Integrated Business Plan, Long Term Financial Model, and update on shadow Historical Due Diligence actions	Nov-12	On track to deliver	
24	Board observation	Nov-12	On track to deliver	This is not in the control of the Trust
25	Historical Due Diligence Phase 1	Nov-12	On track to deliver	Completed on 13 September 2012, final report received and action plan drawn up
26	Executive to Executive meeting	Dec-12	On track to deliver	
27	Historical Due Diligence Feedback to Trust within 10 days	Dec-12	On track to deliver	see 10 above
28	Report on the outcome of consultation/engagement	Jan-13	On track to deliver	
29	Fourth formal submission to include final draft of Integrated Business Plan, Long Term Financial Model, outcome of consultation, legal confirmation of constitution and letter of support from commissioners.	Jan-13	On track to deliver	
30	Q3 Performance and Financial Review: 2012/13 Financial Plan on Track, Cost Improvement Plan trajectory delivered, service performance on track	Feb-13	On track to deliver	
31	Board to Board to approve application	Feb-13	On track to deliver	
32	Historical Due Diligence Phase 2	Feb-13	On track to deliver	
33	Department of Health applies to Department of Health	Mar-13	On track to deliver	
34				
35				
36				
37				
38				
39				
40				

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	Portsmouth Hospitals NHS Trust	Period:	September 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	AR
Financial Risk Rating (Assign number as per SOM guidance)	1
Contractual Position (RAG as per SOM guidance)	AG

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is satisfied that plans in place **are sufficient** to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below.

The board is suggesting that at the current time there is **insufficient assurance available** to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.

Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:		

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**Reported and normalised year-to-date financial risk rating**
The Issue :	**The Trust's reported FRR at the end of September 2012 was 1 (with no normalising adjustments).**
Action :	- Additional CIPs of £4m have been identified by Clinical Service Centres and corporate functions, which are in implementation to recover the position and improve the FRR; - Temporary staffing sign off escalated to Executive Director level; - Cessation of high cost nursing agencies; - Closure of "winter" ward capacity; - Standardisation of junior doctor pay rates; - Cessation of specific high cost projects; - Cessation of weekend working for elective activity; - Review and rationalisation of corporate functions expenditure.

Target/Standard:	**Reported and normalised forecast outturn financial risk rating**
The Issue :	**The Trust's forecast 2012/13 outturn FRR at the end of September 2012 was 2 (with no normalising adjustments).**
Action :	This end of year rating is driven by the Trust's liquidity position which due to overriding rules bring the overall FRR down to 2. An additional working capital facility will be required to increase this rating to a 3 in the short term and this has been agreed with the SHA and included as part of the Trust's LTFM.
Target/Standard:	**All cancers: 62-day wait for first treatment**
The Issue :	**All cancers: 62-day wait for first treatment' targets were not achieved in September 2012**
Action :	The Trust's cancer steering group has established a rolling rota of specialty presentations to ensure visibility of current and forecast operational pressures. A number of pathway reviews had been undertaken prior to the breach of targets; performance improvement plans have been established and are in implementation (in particular, additional clinician and theatre capacity has been secured to improve flexibility and reduce waiting times). Improvements to cancer assurance and reporting processes are under implementation. Approval to secure external support from IMAS has been sought from the SHA and commissioners

Target/Standard:	**A&E: from arrival to admission/transfer/discharge**
The Issue :	**The ED target was failed due to the challenges in flexing capacity, particularly senior medical, to meet an unexpected increase in attendances at the start of the month.**
Action :	A number of trust-wide workstreams have been developed and are in implementation to improve patient flow a) from ED and b) from the Trust's acute wards, including: The establishment of a discharge improvement group, to improve utilisation of the discharge lounge; Undertaking a two-month pilot of the full capacity protocol in two medical specialties; Re-balancing the acute wards, to improve patient flow and increase capacity in pressurised areas; and Establishing an electronic-dashboard to ensure visibility of available beds. Further actions in development include: The development and implementation of a discharge to access ward for older people; and The purchase of discharge services from Medicare (initially on a pilot basis).

Target/Standard:	**Contractual data: Are both the NHS Trust and commissioner fulfilling the terms of the contract?**
The Issue :	**Contractual performance standards have been breached by the Trust in September 2012 in relation to cancer, RTT, ED and PPCI targets.**
Action :	See above in relation to ED and cancer. Performance improvement plans have been established in relation to performance against the PPCI metrics; both emphasise early internal and external communication on appropriate clinical pathways and relevant training programmes (also both internal and external) are in place. Breach of the RTT target (at a specialty level) has resulted from action taken to improve the profile of specialty-level waiting lists.

GOVERNANCE RISK RATINGS

Portsmouth Hospitals NHS Trust

Insert YES, NO or N/A (as appropriate)

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	No	No	Yes	Yes	Yes	Yes	Yes	
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	No	No	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	No	No	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	No	No	No	Yes	No	The Trust can demonstrate 100% compliance with the use of the checklist, however, full completion of all 3 sections consistently can not be evidenced.
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	No	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	No	Yes	Yes	Yes	No	No	No	Failure of the 62-day cancer screening target primarily resulted from complexities within the lower gastrointestinal treatment pathway; a pathway review has been undertaken and a
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	No	No	Yes	Yes	No	No	Failure of the ED standard in September resulted from challenges in matching senior medical capacity to unexpected increase in demand
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Contractual ceiling is 67 cases
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	No	No	Yes	Yes	No	Yes	No	Contractual ceiling is 4 cases: 2 cases in August (one in Q1)
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
				TOTAL		5.5	5.5	2.5	0.5	2.5	2.0	3.5	
						R	R	AR	G	AR	AR	AR	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

Ref	Overriding Rules - Nature and Duration of Override at SHA's Discretion		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	Comments
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective	No	No	No	No	No	No	No	
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Breaches its full year objective Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No	No	No	
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	Yes	Yes	No	No	No	No	No	
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	Yes	Yes	No	No	No	No	
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No	No	No	
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.	Yes	Yes	No	No	No	No	No	
		Number of Overrides Triggered	***2.0***	***3.0***	***1.0***	***0.0***	***0.0***	***0.0***	***0.0***	

FINANCIAL RISK RATING

Portsmouth Hospitals NHS Trust

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	3	2	3	Year to date reflects I&E position being off plan
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	2	3	2	3	Year to date reflects I&E position being off plan
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	3	1	3	Reflects weak I&E position at month 6
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	Year to date reflects I&E position being off plan
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	1	1	1	1	Reflects weak cash position
Weighted Average		**100%**						1.4	2.3	1.4	2.3	
Overriding rules								1	2	1	2	
Overall rating								**1**	**2**	**1**	**2**	

Overriding Rules :

Max Rating	Rule					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	One Financial Criterion at "1"			2		2
3	One Financial Criterion at "2"					
1	Two Financial Criteria at "1"		1		1	
2	Two Financial Criteria at "2"		2		2	

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

Portsmouth Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

	Criteria	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where risks are triggered
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	Yes	Yes	Yes	Yes	Yes	Corresponds to overall I&E position being adrift of plan. Actions have been taken to recover position.
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Weakness of Trust's liquidity position means that Trust is unlikely to score higher than a 2 until this recovers.
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	No	Yes	Yes	Yes	Yes	Yes	Yes	Primarily the result of inter NHS disputes which are being proactively managed with some being resolved in August.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No	No	No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	Interim now in place for one quarter end.
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	A result of in year I&E deficit together with weak brought forward cash position owing to large defict in 2009/10
9	Capital expenditure < 75% of plan for the year to date	Yes	Yes	Yes	Yes	No	No	Yes	Some schemes being profile in earlier months of the year but expecatation is that this will be recovered.

CONTRACTUAL DATA

Portsmouth Hospitals NHS Trust

Insert "Yes" / "No" Assessment for the Month

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	No	No	No	No	No	No	No	Contractual performance standards have been breached by the Trust in September 2012 in relation to cancer, PPCI , ED and Surgery admitted RTT targets, and delivery of MRSA trajectory.
Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
Might the dispute require SHA intervention or arbitration?	N/a	N/a	N/a	N/a	N/a	No	No	
Are the parties already in arbitration?	N/a	N/a	N/a	N/a	N/a	No	No	
Have any performance notices been issued?	No	No	Yes	Yes	No	No	No	No performance notices were received in August 2012; however, the contract issues above may result in performance notices being issued.
Have any penalties been applied?	No	No	No	No	No	Yes	No	Penalties will be applied in relation to the August cancer 62 day target breach

QUALITY

Portsmouth Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Comments on Performance in Month
1	SHMI - latest data	Ratio	99.0	99.0	99.0										Data currently only available for Jan - Dec 2011 on Dr Foster
2	Venous Thromboembolism (VTE) Screening	%	91.4	91.87	93.7	90.81	92.93	92.93	93.24	93.7	93.4	93.6	94.3	94.61	
3a	Elective MRSA Screening	%	75	78.6	77.2	76.8	74.8	74.6	71.5	68.4	64.3	66.1	64	64.3	
3b	Non Elective MRSA Screening	%	83.8	84.5	83.7	81.3	84.6	80.3	82.9	82.7	83.9	84.2	82.1	82.2	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	10	8	6	9	14	2	18	14	2	14	10	6	data includes HCAI, VTE, pressure ulcers and general 'clinical' SIRIs
6	"Never Events" in month	Number	0	0	0	0	0	0	0	0	0	0	1	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	0	0	0	0	0	0	0	2	1	Not sure if this relates to alerts over deadline as there will always be open alerts as they get published. The Trust has
9	RED rated areas on your maternity dashboard?	Number	1	2	4	3	3	3	4	5	3	3	3	1	The reds are not all for the same categories each month.
10	Falls resulting in severe injury or death	Number	0	1	1	0	2	0	0	0	0	0	0	0	
11	Grade 3 or 4 pressure ulcers	Number	6	3	2	4	7	1	4	4	2	3	2	5	
12	100% compliance with WHO surgical checklist	Y/N	N	N	N	N	N	N	N	N	N	N	N	N	The Trust can demonstrate 100% compliance with the use of the checklist, however, full completion of all 3 sections
13	Formal complaints received	Number	43	61	47	58	43	39	41	49	33	46	32	41	August performance corrected to 32 (from 36) following internal review.
14	Agency as a % of Employee Benefit Expenditure	%	3.8	5.06	4.57	5.05	5.76	6.82	5.79	6.64	6.26	6.52	4.82	4.22	
15	Sickness absence rate	%	3.21	3.2	3.29	3.4	3.79	3.45	3.41	3.41	3.08	3.3	3.1	nya	Reported one month in arrears
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	100	100	100	100	100	100	100	100	100	100	100	100	

Board Statements

Portsmouth Hospitals NHS Trust
September 12

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SHA's Provider Management Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	No
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust remains at all times compliant with has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO			
Chair			

Notes

Ref	Indicator	Details
Thresholds		The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation